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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10884
CERTIFICATE OF DEATH
10875

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 12 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, If institutions: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 106 WILLS CREEK AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) THOMAS EDGAR ARDINGER		4. DATE OF DEATH Month OCT. Day 1 Year 1961		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 12, 1900		9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yard Master				10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.				11. BIRTHPLACE (County & State, or foreign country) W.VA. Berkeley County U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME THOMAS ARDINGER				14. MOTHER'S MAIDEN NAME FLORENCE SUE POISAL				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma lung - metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												INTERVAL BETWEEN ONSET AND DEATH 6 mos							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour a.m. p.m. 19		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Algonquin Hotel, Cumberland, Md.		(County) Cumberland		(State) Md.							
21. I certify that (I) (this hospital) attended the deceased from May 10, 1961 to 10/1/61 , that (I) (we) last saw the deceased alive on 10/1/61 , and that death occurred on 10/2/61 from the causes and on the date stated above.																			
22a. SIGNATURE George M. Simons 22c. PHYSICIAN'S NAME (Type) George M. Simons				M.D. Algonquin Hotel, Cumberland, Md.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Algonquin Hotel, Cumberland, Md.				22b. DATE SIGNED 10/2/61							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/4/61				23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park				23d. LOCATION (City, town or county) Cumberland, Md.							
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, ADDRESS Cumberland, Md.				25a. REC'D BY REGISTRAR DATE OCT 5 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

10875

10884

(M)

ALLIANCE

MARYLAND

ALLIANCE

CUMBERLAND

15 DAYS

CUMBERLAND

100 VILLS CREEK AVE

NEUTRAL HOSPITAL

COT. 1 10

ARDINGER

THOMAS

NOV. 12, 1900

X

WHITE

W. VA. WORKING PARTY U.S.A.

U.S.A.

Y. M. C. A.

FLORIDA SUB. POLICE

THOMAS ARDINGER

CUMBERLAND, MD.

NEUTRAL HOSPITAL

Handwritten signature

Handwritten signature

10:37 AM

10/12/01

Winnipeg Hotel, Cumberland, MD.

Winnipeg Hotel, Cumberland, MD.

Winnipeg Hotel, Cumberland, MD.

Handwritten signature

Winnipeg Hotel, Cumberland, MD.

Winnipeg Hotel, Cumberland, MD.

Winnipeg Hotel, Cumberland, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10885

CERTIFICATE OF DEATH

10876

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY in b 6 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE WEST VIRGINIA f. COUNTY MORGAN c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PAW PAW d. STREET ADDRESS -	
3. NAME OF DECEASED (Type or print) DANIEL H. ARNICA		4. DATE OF DEATH Month Day Year OCTOBER 23 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 14, 1873
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY BLOOMERY, W. VA.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME WILLIAM HENRY ARNICA		14. MOTHER'S MAIDEN NAME REBECCA ANDERSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 234-01-6211	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 422d DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Chronic			
INTERVAL BETWEEN ONSET AND DEATH 3 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 19 60 to Oct 19 61 , that (I) (we) last saw the deceased alive on Oct 23 19 61 , and that death occurred at 10:55 PM from the causes and on the date stated above.			
22a. SIGNATURE Dr. G. O. Himmelwright		22b. DATE SIGNED 10/23/61	
22c. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT		22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 26, 1961	
23c. NAME OF CEMETERY OR CREMATORY CAMP HILL		23d. LOCATION (City, town or county) (State) PAW PAW, W. VA.	
24. FUNERAL DIRECTOR'S SIGNATURE PARKS-JOHNSON G. BERKELEY SPOGS.		25a. REC'D BY REGISTRAR W. VA.	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume		DATE OCT 27 '61	

10885

10885

WOMAN

WEST VIRGINIA

ALLEGANY

PAW PAW

3 DAYS

CAMPBELL

MEMORIAL HOSPITAL
1001 1/2 WASHINGTON AVE.

10 OCTOBER 23

ARMY

H.

DAVID

DECEMBER 11, 1933

WHITE

MALE

U.S.A.

BLOOMING, N.Y.

WATSON

REBECCA ANDERSON

WILLIAM HENRY ARMISTEAD

MEMORIAL HOSPITAL, CUMBERLAND, MD.

10885

10:30 P.M.

X

100 VIRGINIA AVE., CUMBERLAND, MD.

100 VIRGINIA AVE., CUMBERLAND, MD.

OCT 23 1933

10885



VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday)		10. BIRTHPLACE (State or foreign country)	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Arteriosclerotic Vascular Disease.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>21 Days.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR		24. REC'D BY REGISTRAR	
24b. REGISTRAR'S SIGNATURE		DATE	

10878

10886



Allegany

Allegany

Allegany

Chamberlain, Maryland

Chamberlain

33 S. Centre St.

Memorial Hosp.

Col. 21

21

21

21

21

1880

Jan

White

Frederick House

Rockville

U.S.A.

Rayner, Wm.

Howe

John Rane (deceased)

John Rane (deceased)

W. V. J. Rane, Chamberlain, Md.

no

General Reference

Antisocialistic Vanouder Disease

October 1, 1911

W. V. J. Rane, Chamberlain, Md.

W. V. J. Rane, Chamberlain, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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(M)

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10887											
10878											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND						c. LENGTH OF STAY IN 1b 5 DAYS					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL						d. STREET ADDRESS 124 MAIN ST.					
3. NAME OF DECEASED (Type or print) EMMA						4. DATE OF DEATH OCT. 2 19 61					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 11, 1881		9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) PA. Pine,		12. CITIZEN OF WHAT COUNTRY U. S. A.		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME Richard Lee						14. MOTHER'S MAIDEN NAME Lucinda?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) none						16. SOCIAL SECURITY NO. none					
17. INFORMANT PATIENT'S CHART						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 4-20-61 DUE TO Conditions, if any, which gave rise to immediate cause (b) arteriosclerotic heart disease (c) Generalized arteriosclerosis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 1/2 hr 2 1/2 hrs											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 9-16 , 19 61 , to 10-2 , 19 61 , that (I) (we) last saw the deceased alive on 10-1 , 19 61 , and that death occurred at 10-2 , 19 61 , from the causes and on the date stated above.											
22a. SIGNATURE L. Brings						22b. DATE SIGNED 10/3/61					
22c. PHYSICIAN'S NAME (Type) LEWIS BRINGS, M.D.						22d. ADDRESS 57 GREENE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/5/61		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town or county) Cumberland, Maryland		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer						25a. REC'D BY REGISTRAR OCT 4 '61					
ADDRESS Cumberland, Maryland						25b. REGISTRAR'S SIGNATURE Charles L. Hines					

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10888
CERTIFICATE OF DEATH
10880

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, c. LENGTH OF STAY IN 1b 20 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY d. STREET ADDRESS 26 BRIDGE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PAUL William BOND		4. DATE OF DEATH Month OCTOBER Day 29 Year 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 14, 1904
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.CO.	
11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN W. BOND		14. MOTHER'S MAIDEN NAME Sarah Y KESNER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No,		16. SOCIAL SECURITY NO. 217-10-1776	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis Shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Bacteremia (a), stating the underlying cause last. (c) Left pyomyositis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Coronary Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19 Oct 1961 to 29 Oct 1961 , that (I) (we) last saw the deceased alive on 28 Oct 1961 , and that death occurred at 10 A.M. from the causes and on the date stated above.			
22a. SIGNATURE James C. Stegmair M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. STEGMAIER DR. XXXXXXXXXXXXXXXX		22d. ADDRESS 122 S. CENTRE ST. XXXXXXXXXXXXXXXXXX, CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/31/61	23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Cem.	23d. LOCATION (City, town or county) (State) Cumberland, Md.
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE NOV 2 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

10880

10888

M

MINERAL

WEST VIRGINIA

ALLEGANY

RIDGELEY

50 DAYS

CUMULATIVE

25 BRIDGE STREET

MINERAL HOSPITAL

19

23

OCTOBER

BOND

22-10-1917

PAUL

X

27

MARCH 10, 1917

WHITE

MALE

U.S.A.

WEST VIRGINIA

E. A. O. P. B. CO.

CARPENTER

JOHN W. BOND

JOHN W. BOND

MINERAL HOSPITAL - CUMULATIVE, MARYLAND

1325 S. CENTRE ST.
ALLEGANY COUNTY, WEST VIRGINIA

DR. STEWART
DR. KAY

MINERAL HOSPITAL, CUMULATIVE

Dr. George Chamberlain, M.D.
10/1/17

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10889

10881

1. PLACE OF DEATH a. COUNTY ALLEGANY b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 2 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL d. STREET ADDRESS 316 FREDERICK ST.				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NELLIE b. DATE OF DEATH OCT. 16 19 61				4. DATE OF DEATH Month OCT. Day 16 Year 19 61			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH SEPT. 13, 1885		9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 76 Days 0 Hours 0 Min. 0			
11. BIRTHPLACE (County & State, or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME GEORGE LAYMAN (DECEASED)				14. MOTHER'S MAIDEN NAME ANNIE L. Crowe (DECEASED)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMATION PATIENT'S CHART				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Dioxide Narcosis (b) 194X DUE TO Carcinoma of the thyroid (c) 5 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from 17 Aug 1961 to 16 Oct 1961 that (I) (we) last saw the deceased alive on 15 Oct 1961 and that death occurred at 6 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Louis M. Gliele				22b. DATE SIGNED 17 Oct 61			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/19/61		23c. NAME OF CEMETERY OR CREMATORY Frostburg Memo. Pk. Frostburg Md.			
23d. LOCATION (City, town or county) Md.		24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. Md.					
25a. REC'D BY REGISTRAR OCT 20 61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas					

TO BE FILLED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

10883

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Received 10/11/61 from Mr. J. H. [illegible]
for the sum of \$100.00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10890
CERTIFICATE OF DEATH
10882

1. PLACE OF DEATH e. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 02 CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED H EART		d. STREET ADDRESS 35 HUMBERD STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE F. BUSKEY		4. DATE OF DEATH OCTOBER 28, 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-17-93
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Pipefitter Railroad		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME GEORGE M. BUSKEY		14. MOTHER'S MAIDEN NAME KATHERINE BUSKEY (Decker)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes War I		16. SOCIAL SECURITY NO. 705-05-4780	
17. INFORMANT CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 155.0 DUE TO Hepstoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-15 to 10-28 , 19 61 , that (I) (we) last saw the deceased alive on 10-27 , 19 61 , and that death occurred at 7:45 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Earl Paul		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Earl Paul, M.D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-31-1961	
23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE NOV 1 '61	
25b. REGISTRAR'S SIGNATURE Arthur E. Kneass			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10891 CERTIFICATE OF DEATH 10883

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 107 POLK STREET	
3. NAME OF DECEASED (Type or print) First HARRY Middle N Last CURTIS		4. DATE OF DEATH Month 10 Day 23 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 17, 1892
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Candy INDUSTRY		9b. AGE (In years last birthday) 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Candy INDUSTRY		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) GREECE		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME NICOLAS CURTIS		14. MOTHER'S MAIDEN NAME FONTINI (Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-03-9342	
17. INFORMANT Anthony Anatonkas		Address 72 Baltimore Street, Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute monomyelocytic leukemia 2043 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombocytopenia; severe secondary anemia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/28 , 1961 , to 10/23 , 1961 , that (I) (we) last saw the deceased alive on 10/22 , 1961 , and that death occurred at 7:05 A.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Samuel M. Jacobson</i> M.D.		22b. ADDRESS 50 Pershing St. Cumberland, Md.	
22c. PHYSICIAN'S NAME (Type) Samuel M. Jacobson, M. D.		22d. ADDRESS 50 Pershing St. Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/25/61	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town or county) (State) Cumberland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		25a. REC'D BY REGISTRAR OCT 26 '61	
ADDRESS Cumberland Maryland		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10892 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10884

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 949 Maryland Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 949 Maryland Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN RICHARD DARR				4. DATE OF DEATH Month October Day 12 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 14, 1918	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infantryman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John R. Darr, Sr.				14. MOTHER'S MAIDEN NAME Minnie Hollow			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 2				16. SOCIAL SECURITY NO. 218-24-8276			
17. INFORMANT Raymond E. Darr, Parkville, Maryland				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS WITH THROMBOSIS DUE TO (c) ---						INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Oct. 16, 1961			
22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cemetery				22d. LOCATION (City, town, or country) (State) Nr. Cumberland, Md.			
23. FUNERAL DIRECTOR Charles L. George, 202 Greene St. Cumberland, Md.				24a. REC'D BY REGISTRAR OCT 16 '61			
				24b. REGISTRAR'S SIGNATURE Arthur S. Thoma			

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Missile Section

John E. Hart, Sr.

Raymond A. Hart, Christiansburg, Virginia

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COMPANY 2110131 WITH 2110131

Mr. Christiansburg, Va.

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Charles J. Jones, 208 Grove St. Christiansburg, Va.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10885

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN TB <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Route 4, Box 87, Oldtown Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>F.</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>14</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 23, 1887</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maysville, W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Henry Frantz</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Hawk</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Mrs. John Emery, Cumberland, Md.</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA, CARDIAC FAILURE</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CHRONIC MYOCARDITIS</u> (a), stating the underlying cause last, DUE TO (c) <u>CORONARY SCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>FRACTURE RIGHT HIP</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Descending stairs, missed bottom step and fell</u>							
20b. TIME OF INJURY Hour <u>7:15</u> p.m. Month, Day, Year <u>Oct. 19 61</u>		20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20e. (City or town) <u>Cumberland-Allegany</u> (County) <u>Md.</u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>OCT, 14, 1961</u> Address (Street, city, town, or county) <u>Cumberland, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 17, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR <u>James F. Scarpelli, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

Item 18 Filed 298
10-30-61 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10894

10886

1. PLACE OF DEATH a. COUNTY Allogany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allogany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11/6/59	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allogany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fannie Middle Rachael Last Dean		4. DATE OF DEATH Month October Day 5 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/30/1876
9. AGE (In years lost birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Thurman, New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ephram Tucker		14. MOTHER'S MAIDEN NAME Mary Jane Perkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O.Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Virus Infection, Pulmonary DUE TO (b) Diabetes Mellitus (c) Cerebral apoplexy CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old fracture left hip		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/6/59 19 to 10/5/61 19, that (I) (we) last saw the deceased alive on 10/5/61 @ 1:50 P.M. and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Dr. Lee B. Mathews		22b. DATE SIGNED 10/6/61	
22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/8/61	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
25a. REC'D BY REGISTRAR DATE OCT 9 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Francis	

5. <http://www.irs.gov/efile>

2000

1945

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10887

10895

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>Yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>449 N. Centre St.</u>				d. STREET ADDRESS <u>449 N. Centre St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>ABNER</u> Middle <u>ROSS</u> Last <u>DEITRICH</u>				4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>1961</u>						
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 17, 1887</u>		9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Contr. Painting</u>		11. BIRTHPLACE (State or foreign country) <u>Lebanon County, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Cyrus Deitrich</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Miller</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W.1</u>		17. INFORMANT Address <u>Mrs. Florence Deitrich Cumberland, Maryland</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CORONARY SCLEROSIS</u> (a), stating the underlying cause lost. DUE TO (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED				
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Oct. 12, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Patricks, Cemetery</u>				
22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>										
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein</u>				ADDRESS <u>117 Frederick St. Cumb. Md.</u>		24a. REC'D BY REGISTRAR <u>OCT 13 '61</u>				
24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>										

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1983

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1983

Name of Deceased		Date of Death	
John Doe		10/17/83	
Age		Sex	
65		Male	
Race		Marital Status	
White		Married	
Place of Birth		Usual Residence	
Baltimore, Md.		Baltimore, Md.	
Cause of Death		Manner of Death	
Heart Disease		Natural	
Immediate Cause		Contributing Cause	
Myocardial Infarction		Hypertension	
Site and Extent of Injuries		Toxicology	
None		None	
Signature of Examiner		Signature of Physician	
[Signature]		[Signature]	
Date of Examination		Date of Death	
10/17/83		10/17/83	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10896						10888					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY ALLEGANY						a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND						b. COUNTY ALLEGANY					
c. LENGTH OF STAY IN 1b 10 hrs. 45 min.						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART						d. STREET ADDRESS 453 HENDERSON AVENUE					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last ANNETA E. FRADISKA						Month Day Year OCTOBER 26, 1961					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH XXX 7-22-84		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN ELBIN						14. MOTHER'S MAIDEN NAME AMANDA ELBIN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT PT'S CHART Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) arteriosclerosis (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 2 hrs 1 year											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-26-61 to 10-26-61 , that (I) (we) last saw the deceased alive on 10-26-61 , and that death occurred at 10-26-61 M, from the causes and on the date stated above.											
22a. SIGNATURE L. Brings						M.D. Lewis Brings, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-28-61	
22c. PHYSICIAN'S NAME (Type) Lewis Brings, M.D.						22d. ADDRESS 576 Green St. Cumberland Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/28/61		23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		23d. LOCATION (City, town or county) Allegany County		23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer						ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR OCT 30 '61		25b. REGISTRAR'S SIGNATURE Clifford S. Thomas	

530

3221

0573-0730

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

10897

STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10889

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 50 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 440 N. Mechanic Street				d. STREET ADDRESS 440 N. Mechanic Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MINTIE Middle SARAH Last FRAME				4. DATE OF DEATH Month October Day 13 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/11/1881	
9. AGE (In years lost birthday) 80 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		11. BIRTHPLACE (State or foreign country) Rosedale, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Rosedale, W. Va.	
13. FATHER'S NAME James Shamblin				14. MOTHER'S MAIDEN NAME Evelyn Bishop			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Harry Duckworth Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Concussion of the lungs 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Cumberland, Maryland				20g. (County) Cumberland			
21. I certify that (I) (this hospital) attended the deceased from 3-1-1961 to 10-13-1961 , that (I) (we) lost the deceased alive on 10-10-1961 , and that death occurred at 7:45 AM , from the causes and on the date stated above.							
22a. SIGNATURE L. B. B. B.				22b. DATE SIGNED 10-14-61		22c. PHYSICIAN'S NAME (Type) L. B. B. B.	
22d. ADDRESS Cumberland, Maryland				22e. ADDRESS Cumberland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/16/61		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer				25a. REC'D BY REGISTRAR DATE OCT 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Brown	

1088

CERTIFICATE OF TREATMENT

10887

(M)

(1)

CHIEF CLERK

20 DEC 1961

10898

CERTIFICATE OF DEATH

Reg. Dist. No. 10898

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 409 Ascension St.				d. STREET ADDRESS 409 Ascension			
3. NAME OF DECEASED (Type or print) First Bernard Middle Leroy Last Gehauf				4. DATE OF DEATH Month October Day 10 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 7, 1900	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry W. Gehauf				14. MOTHER'S MAIDEN NAME Nellie Wolfe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Hazel M. Gehauf Address 409 Ascension St. Cumb. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Congestive Heart Failure DUE TO (c) Coronary Thrombosis						INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 hours 10 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio sclerosis. Atherosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 July 1959 to 10 Oct 1961 , that I last saw the deceased alive on 10 Oct 1961 , and that death occurred at 8:17 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 707 Montgomery Ave. Cumberland, Md. DATE SIGNED							
ACTUAL SIGNATURE David T. Rees M.D.				PHYSICIAN'S NAME (Type) DAVID T. REES M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 13, 1961		22c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Louis S. J. J. ADDRESS 117 Frederick St. Cumb. Md.				24a. REC'D BY REGISTRAR DATE OCT 13 '61		24b. REGISTRAR'S SIGNATURE Charles S. Hines	

1

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS 61 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
10899											
1. PLACE OF DEATH a. COUNTY ALLEGANY				2. RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				e. STREET ADDRESS 512 GREENE STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MAURINE Middle IRENE Last GILMORE				4. DATE OF DEATH Month 10 Day 1 Year 1961							
5. SEX FEMALE		6. COLOR OR RACE COLORED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/10/31		9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, or foreign country) WEST. VIRGINIA			
12. CITIZEN OF WHAT COUNTRY? UNITED STATES				13. FATHER'S NAME WILBUR POWELL				14. MOTHER'S MAIDEN NAME PEARL G. POWELL FIELDS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT CHART			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 241X DUE TO Status Asthmaticus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 weeks											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 10/2/61 , 19 61 to 10/1/61 , 19 61 that (I) (we) last saw the deceased alive on 10/1/61 , and that death occurred at 10 AM , from the causes and on the date stated above.											
22a. SIGNATURE B. M. Schindler				M.D. DR. B. SCHINDLER M. D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/2/61	
22c. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER M. D.				22d. ADDRESS 43 GREENE STREET, CUMBERLAND, MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/3/61		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Burial Park				23d. LOCATION (City, town or county) (State) Cumberland, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				ADDRESS				25a. REC'D BY REGISTRAR DATE OCT 4 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

10801

28901

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10900

CERTIFICATE OF DEATH

10892

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL & WARWICK AVE. MEMORIAL HOSPITAL				d. STREET ADDRESS 942 GAY ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) NETTIE B. GRAY				4. DATE OF DEATH Month OCTOBER Day 16 Year 1961			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-5-1893	9. AGE (In years last birthday) yrs. 67	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CLAY BRIDGES				14. MOTHER'S MAIDEN NAME MARGARET BARTHOLOW			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Carcinoma of Uterus 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Adenocarcinoma of Uterus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 1956 to Oct , 19 61 , that (I) (we) last saw the deceased alive on Oct 16 , 19 61 , and that death occurred at 10:10 P.M. , from the causes and on the date stated above.							
22a. SIGNATURE DR. G. O. HIMMELWRIGHT				22b. DATE SIGNED 10/19/61			
22c. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT				22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-19-1961		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR OCT 24 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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ALLEGANY

ALLEGANY

ALLEGANY

CUMBERLAND

CUMBERLAND

912 DAY ST.

912 DAY ST.

MEMORIAL HOSPITAL

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B.

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11-11-33

11-11-33

WHITE

FEMALE

REYNOLDS

REYNOLDS

MARGARET BATHURST

CLAY BRIDGES

MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEMORIAL HOSPITAL

MEMORIAL HOSPITAL



James P. Thompson

James P. Thompson

10:10 P.M.

10:10 P.M.

10:10 P.M.

137 VIRGINIA AVE., CUMBERLAND, MD.

137 VIRGINIA AVE., CUMBERLAND, MD.

137 VIRGINIA AVE., CUMBERLAND, MD.

137 VIRGINIA AVE., CUMBERLAND, MD.

137 VIRGINIA AVE., CUMBERLAND, MD.

137 VIRGINIA AVE., CUMBERLAND, MD.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 Medical Examiner's permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

2

VS. A1SME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10901 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10893

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY in lb LIFE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 214 COLUMBIA STREET			d. STREET ADDRESS 214 COLUMBIA STREET		
3. NAME OF DECEASED (Type or print) RICHARD LEE GRAY, JR.			4. DATE OF DEATH Month Day Year OCT. 9 19 61		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 28, 1961		9. AGE (In years last birthday) yrs. 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME RICHARD LEE GRAY, SR.			14. MOTHER'S MAIDEN NAME MARY G. SMITH		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO			16. SOCIAL SECURITY NO. NONE		
17. INFORMANT RICHARD LEE GRAY, SR.			Address CUMBERLAND, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIAATION 7620 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) ASPIRATION OF STOMACH CONTENTS DUE TO (c) 3-5 Min.					INTERVAL BETWEEN ONSET AND DEATH 3-5 Min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic		M.D.		DATE SIGNED October 9, 1961	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		Address (Street, city, town, or county) ACumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF OCT. 11, 1961	22c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK		22d. LOCATION (City, town, or country) CUMBERLAND, MD.	
23. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.		24a. REC'D BY REGISTRAR OCT 11 '61	24b. REGISTRAR'S SIGNATURE C. J. H. H. H.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10902

CERTIFICATE OF DEATH

10894

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY in 1b 17 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND d. STREET ADDRESS 30 BOONE ST. 147 COLUMBIA ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) EVELYN K. GUTHRIDGE		4. DATE OF DEATH OCTOBER 30, 19 61		5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-14-1912		9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSES AIDE				10b. KIND OF BUSINESS OR INDUSTRY HOSPITAL				11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.				12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME FRANK E. LEWIS				14. MOTHER'S MAIDEN NAME JESSIE LEWIS													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO				16. SOCIAL SECURITY NO. 217 10 7779				17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Cervix with regional metastatic disease of rectum, lungs - 171X DUE TO (b) Sacral Spine, femurs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Sacral Spine, femurs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 yrs																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) april 1961		20g. (County) 10/30		20h. (State) 1961		20i. (City or town) 3:55 P.M.		20j. (County) 11-1-61	
21. I certify that (I) (this hospital) attended the deceased from april 1961 to 10/30 , 19 61 , that (I) (we) last saw the deceased alive on 10/30 , 19 61 , and that death occurred at 3:55 P.M. from the causes and on the date stated above.																	
22a. SIGNATURE Weissman M.D.				22b. DATE SIGNED 11-1-61				22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISSMAN				22d. ADDRESS 59 GREENE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/2/1961				23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park				23d. LOCATION (City, town or county) (State) Cumberland, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.				25a. REC'D BY REGISTRAR NOV 3 '61				25b. REGISTRAR'S SIGNATURE Charles L. Thomas					

VR A15 (4)
15M 9/60

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CUMBERLAND

17 DAYS

CUMBERLAND

MEMORIAL & WARDEN HOSPITAL
GENERAL HOSPITAL

101 COLUMBIA ST.

OCTOBER 30, 1941

BUTTRICK

K.

CALVIN

NO

3-14-1942

WHITE

U. S. A.

JEFFREY LEWIS

FRANK E. LEWIS

MEMORIAL HOSPITAL - CUMBERLAND, MD.

3:30 P.M.

33 WILSON ST., CUMBERLAND, MD.

DR. S. D. VICK

NOV 9 1941



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10903

10895

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS RT. #2, BOX 446 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) EMMA S. HANDLEY		4. DATE OF DEATH Month OCTOBER Day 5 Year 1961				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 26, 1892	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JAMES W. VINEY		14. MOTHER'S MAIDEN NAME SARAH S. FOWLER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 260X DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized Atherosclerosis (a), stating the underlying cause last. DUE TO Diabetes mellitus (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 36 hr						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1953 to 1961 , that (I) (we) last saw the deceased alive on 10/5 19 61 , and that death occurred at 1:32 A.M. from the causes and on the date stated above.						
22a. SIGNATURE Dr. George M. Simons M.D.		22b. ADDRESS ALGONQUIN HOTEL - CUMBERLAND, MD.		22c. DATE SIGNED 10/7/61		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/7/61		23c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		23d. LOCATION (City, town or county) Westernport Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland Maryland		25a. REC'D BY REGISTRAR OCT 9 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hume

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ALLEGANY

CUMBERLAND

MC CORMACK HOSPITAL

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HOUSEWIFE

JAMES M. WILLY

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WAGLEY

AUG. 28, 1952

MARYLAND

DAVID S. COLE

GENERAL HOSPITAL - CUMBERLAND, MARYLAND

ALLEGANY

MARYLAND

CUMBERLAND

RT. 2, BOX 440

OCTOBER 5

1951

U.S.A.

DR. GEORGE P. STINGS

LEONARD HOTEL - CUMBERLAND, MD.

WILLIAM F. STINGS

CUMBERLAND

MARYLAND

1952

MARYLAND

1 FOR STATE HEALTH DEPT.

TO DO BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10904 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10896

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 15 minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rawlings		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle STANLEY Last HANSEL				4. DATE OF DEATH Month October Day 15 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1870	9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXXXX Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Ethel Hansel, Rawlings, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE, 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1-2 Hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 15, 1961 Address (Street, city, town, or county) Cumberland, Md.							
ACTUAL SIGNATURE Benedict Skitarelic		M.D.		DATE SIGNED			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 18, 1961	22c. NAME OF CEMETERY OR CREMATORY Biertown Cemetery		22d. LOCATION (City, town, or county) _____ (State) _____			
23. FUNERAL DIRECTOR ADDRESS Charles L. George, Cumberland, Md.				24a. REC'D BY REGISTRAR Oct 18 '61		24b. REGISTRAR'S SIGNATURE <i>Frederick L. Hines</i>	

MEDICAL CERTIFICATION

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TO HO **PITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

662

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
10905					10897									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY <u>Allegany</u>					a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>									
c. LENGTH OF STAY IN 1b <u>8 Hr. 33 Min</u>					d. STREET ADDRESS <u>214 Virginia Ave.</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First Middle Last <u>Richard M. Hansrote</u>					Month Day Year <u>TO 19 61</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 5 1904</u>		9. AGE (In years last birthday) <u>57</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Supply Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>		IF UNDER 1 YEAR Months Days Hours Min.						
13. FATHER'S NAME <u>John Hansrote (d)</u>					14. MOTHER'S MAIDEN NAME <u>Laura Hansrote (d) (Reeder)</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)					16. SOCIAL SECURITY NO. <u>705-09-9936</u>					17. INFORMANT <u>Records-Sacred Heart Hospital</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral Hemorrhage</u> <u>331 X</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u> <u>2 yrs</u> <u>5 yrs</u>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)				
21. I certify that (I) (this hospital) attended the deceased from <u>June 1957</u> to <u>Oct 4 1961</u> ; that (I) (we) last saw the deceased alive on <u>Oct 4 1961</u> , and that death occurred at <u>10:57</u> M, from the causes and on the date stated above.										22b. DATE SIGNED <u>10/5/61</u>				
22a. SIGNATURE <u>Clay H. Durrett</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22d. ADDRESS <u>236 Virginia Ave.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-7-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		23d. LOCATION (City, town or county) <u>Cumberland, Md.</u>		(State)		25a. REC'D BY REGISTRAR <u>OCT 9 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>					ADDRESS					25c. REGISTRAR'S SIGNATURE				

VR A15 (4)
15M 9/60

1021

5924

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

10906

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10898

1. PLACE OF DEATH a. COUNTY Allogany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allogany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 3/13/1957			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allogany County Infirmary				d. STREET ADDRESS 1 110 Bedford Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Louise Middle Weber Last Hartung				4. DATE OF DEATH Month October Day 29 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/10/1876	
9. AGE (In years lost birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Frostburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Robert Welsh				14. MOTHER'S MAIDEN NAME Louise Marson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT P.O. Box 599 Allogany County Infirmary Records.				Address Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Concussion of Stomach 151X DUE TO (b) Arteriosclerosis (general) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 yrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 3/13/57 , 19 to 10/29/61 , 19, that (I) (we) last saw the deceased alive on 10/28/61 9 @ 2:23 P.M. and that death occurred at M, from the causes and on the date stated above.							
22a. SIGNATURE Dr. Lee B. Mathews M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE 10/30/61							
22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews 22d. ADDRESS 49 Greene St., Cumberland, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Oct. 31, 1961 23c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery 23d. LOCATION (City, town, or county) (State) Cumberland, Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Byron Knight ADDRESS Cumberland, Md. 25a. REC'D BY REGISTRAR DATE NOV 2 '61 25b. REGISTRAR'S SIGNATURE Wm. S. Thomas							

10328

10308



STATE OF ALABAMA
COUNTY OF ALABAMA
IN SENATE
JANUARY 1917
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE
TO THE
SENATE
FOR THE
YEAR
1916
BY
J. B. HARRIS
COMMISSIONER
ALBANY, N. Y.
1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
10899

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 9/1/1961		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				d. STREET ADDRESS 126 Greene Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Virginia Middle May Last Heath				4. DATE OF DEATH Month October Day 24 , Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/17/1879	
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min.		11. BIRTHPLACE (State or foreign country) Moorefield, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Moorefield, W. Va.	
13. FATHER'S NAME Lorenzo Halterman				14. MOTHER'S MAIDEN NAME Magdoline Coby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT P.O.Box 599 Allegany County Infirmary Records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, left lower lobe DUE TO (b) Neurosis, chr. degenerative DUE TO (c) Arteriosclerosis, senile PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 48 hrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Cumberland				20g. (County) Allegany			
20h. (State) Md.				20i. (Country) U. S. A.			
21. I certify that (I) (this hospital) attended the deceased from 9/1/61 19 to 9/24/61 19, that (I) (we) lost saw the deceased alive on 9/24/61 19, and that death occurred at 11:25 A.M. M, from the causes and on the date stated above.							
22a. SIGNATURE Dr. L. B. Mathews				22b. DATE SIGNED 10/25/61			
22c. PHYSICIAN'S NAME (Type) Dr. L. B. Mathews				22d. ADDRESS 49 Greene St., Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Oct. 27, 1961		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
23d. LOCATION (City, town, or county) Moorefield, W. Va.				23e. (State) W. Va.			
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR 130'61	
25b. REGISTRAR'S SIGNATURE Charles L. George				25c. DATE 10/25/61			

10000

CERTIFICATE OF OWNERSHIP

10000

(M)

THIS CERTIFICATE OF OWNERSHIP is hereby issued to the
owner of the above described property, to wit:
[Property Description]
[Address]
[City, State, Zip]
[Owner Name]
[Signature]
[Date]

[Faint, illegible text block]

[Faint, illegible text block]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10908

10900

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 14 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		d. STREET ADDRESS 126 VIRGINIA AVE.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL									
3. NAME OF DECEASED (Type or print) First SUZETTE Middle HIXON Last HIXON		4. DATE OF DEATH Month OCTOBER Day 31 Year 1961							
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-30-1878		9. AGE (In years last birthday) 83 yrs. IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS.: Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA Cedar Point		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME LAWRENCE HANSROTE				14. MOTHER'S MAIDEN NAME MARY SPRING					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.3 DUE TO <i>Metastatic Carcinoma from Squamous Cell</i> Conditions, if any, which gave rise to immediate cause (b) DUE TO <i>8 months</i> (a), stating the underlying cause last. (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Aug 8:20 P.M.</i> 1954 <i>to</i> <i>Oct</i> 1961 , that (I) (we) last saw the deceased alive on <i>Oct 31</i> 1961 , and that death occurred at <i>8:20 P.M.</i> 1961 , from the causes and on the date stated above.									
22a. SIGNATURE <i>[Signature]</i>				22b. DATE SIGNED 11/2/61		22c. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT			
22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-3-1961		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town or county) Cumberland, Md. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR NOV 6 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

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ALLEGANY

CLINTON

CLINTON

CLINTON

HOSPITAL & VETERAN AVE.
HOSPITAL

150 VIRGINIA AVE.

IX

OCTOBER 31

HIXON

SLETT

1-30-18

1-30-18

1-30-18

WEST VIRGINIA

WEST VIRGINIA

MARY SPRING

LAWRENCE HANCOCK

HOSPITAL - CLINTON

Medical Bureau for Hospital

OCTOBER 31

OCTOBER 31

11/2/01

X

William H. C. Rimmwright

DR. E. C. RIMMWRIGHT

152 VIRGINIA AVE., CLINTON

11-1-18

NOV 8 '01

JAMES L. BENTLEY, CLINTON, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10909

CERTIFICATE OF DEATH

10901

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in Warwick & address) MEMORIAL HOSPITAL			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last David Ronald HOLLIDAY			4. DATE OF DEATH Month Day Year OCTOBER 30 19 61			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 27, 1961		9. AGE (In years last birthday) yrs. Months Days 3 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Infant)			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.						
13. FATHER'S NAME EUGENE R. HOLLIDAY			14. MOTHER'S MAIDEN NAME MARGARET D. RADCLIFF			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No			16. SOCIAL SECURITY NO. None			
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity EDC 16 Dec 61 761-5 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ploenta Granular Centralis						INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) 19		20g. (County) 19		20h. (State) 19		
21. I certify that (I) (this hospital) attended the deceased from 27 Oct 1961 to 30 Oct 1961 that (I) (we) last saw the deceased alive on 30 Oct 1961 and that death occurred at 1:15 P.M. from the causes and on the date stated above.						
22a. SIGNATURE Fuller B. Whitworth M.D.						22b. DATE SIGNED NOV 2 '61
22c. PHYSICIAN'S NAME (Type) DR. FULLER B. WHITWORTH						22d. ADDRESS 123 BEDFORD STREET, CUMBERLAND, MD.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/31/61		23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cemetery		
23d. LOCATION (City, town or county) Cumberland, Md.		23e. (State) Md.				
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George			24b. ADDRESS Cumberland, Md.			
25a. REC'D BY REGISTRAR DATE NOV 2 '61			25b. REGISTRAR'S SIGNATURE Arthur L. Kline			

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ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

3 DAYS

CUMBERLAND

ED MEMORIAL HOSPITAL, MEMPHIS, TENN.,
WASHINGTON

305 HILLOCK AVENUE

ALLEGANY

HOLIDAY

OCTOBER 30

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WHITE

OCTOBER 27, 1901

RECEIVED ()

CUMBERLAND, MARYLAND

U. S. A.

EUGENE R. WILSON

MARGARET D. GACCHER

MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND

123 BEDFORD STREET, CUMBERLAND, MD.

DR. HULLER B. WHITFORTH

10/31/01 2100 Memorial Cemetery, Cumberland, Md.

Charles L. George, Cumberland, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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M
10910
10902
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 7 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONA CONING d. STREET ADDRESS 100 DOUGLAS AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES HOLMES		4. DATE OF DEATH Month OCTOBER Day 5 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 5, 1879
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME THOMAS HOLMES		14. MOTHER'S MAIDEN NAME SUSAN MC FARLANE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic Cardiovascular disease 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastatic Carcinoma of the prostate gland 1947 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-26-61 to 10-5-61 that (I) (we) last saw the deceased alive on 10-4-61 and that death occurred at 3:02 A.M. from the causes and on the date stated above.			
22a. SIGNATURE DR. W. F. WILLIAMS M.D.		22b. DATE SIGNED 10-7-61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 122 S. CENTRE STREET, CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 10/8/61	
23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town or county) (State) Lonaconing, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George Enkhorn ADDRESS Lonaconing, Md.		25a. REC'D BY REGISTRAR DATE OCT 10 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Smith			

M

1

ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

JAMES

WHITE

RETIRED

THOMAS HOLMES

1 DAY

HOLMES

MAY 2, 1879

WAPPING

SUSAN MC FARLANE

MEMORIAL HOSPITAL - CUMBERLAND, MD.

ALLEGANY

WAPPING

CUMBERLAND

100 DOUGLAS AVENUE

OCTOBER

61

U.S.A.

DR. W. F. WILLIAMS

122 S. CENTRE STREET, CUMBERLAND, MD.

CHS HALL

ALLEGANY

100 DOUGLAS AVENUE

MD.

CUMBERLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10911

10903

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG, MD. c. LENGTH OF STAY IN 1b 2 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG, MD. d. STREET ADDRESS 217 CENTRE ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) HARRIETT M. HORNER		4. DATE OF DEATH Month OCTOBER Day 22 Year 1961		5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 20, 1910		9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursing				10b. KIND OF BUSINESS OR INDUSTRY Sibley Hospital				11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN FILER				14. MOTHER'S MAIDEN NAME ELLEN WITCHELL				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 578-03-4685				17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous Carcinoma Cervix 171X DUE TO Conditions, if any, which gave rise to immediate cause (b) General abdominal metastases (c) and intestinal obstruction causa last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH Approx 3 yrs 14 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Aug 8 , 19 60 , to Oct. 22 , 19 61 , that (I) (we) last saw the deceased alive on Oct 22 , 19 61 , and that death occurred at 5:15 PM on the causes and on the date stated above.																			
22a. SIGNATURE Dr. Wylie Faw				22b. DATE SIGNED Oct 24, 1961				22c. PHYSICIAN'S NAME (Type) DR. WYLIE FAW				22d. ADDRESS 122 SOUTH CENTRE ST., CUMBERLAND, MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 10-25-61				23c. NAME OF CEMETERY OR CREMATORY F'BG. MEMORIAL PARK				23d. LOCATION (City, town or county) (State) FROSTBURG, MD.							
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Durst				ADDRESS FROSTBURG, MD.				25a. REC'D BY REGISTRAR Oct 26 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

10003

ALLEGANY

WASTLING

FROSTBURG, MD.

311 CENTRE ST.

OCTOBER 22, 1910

HOMER

JAN. 20, 1910

FROSTBURG, MARYLAND, U.S.A.

ELLEN MITCHELL

MEMORIAL HOSPITAL, CLEVELAND, MD.

10013

ALLEGANY

2 DAYS

FROSTBURG, MD.

MEMORIAL HOSPITAL
MEMORIAL & MARSH AVE

WRESTLETT

WHITE

JOHN TILLY

MEMORIAL HOSPITAL

125 SOUTH CENTRE ST., CLEVELAND, MD.

MEMORIAL HOSPITAL

FROSTBURG, MD.

10-22-10

DR. WILLIAM

1. **FOR STATE HEALTH DEPT.**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10912 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Disl. No. **10904**

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NED Middle RUSSELL Last HOSE				4. DATE OF DEATH Month OCTOBER Day 27TH , Year 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 14TH, 1914	
9. AGE (In years last birthday) 46 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JONAH HOSE				14. MOTHER'S MAIDEN NAME HOPE POPE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 705-10-5930		17. INFORMANT MRS. MARJORIE HOSE, OLDTOWN, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis with Thrombosis DUE TO (c) ?				INTERVAL BETWEEN ONSET AND DEATH Sudden ??			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W O McLane				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) W O McLane M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/30/61		22c. NAME OF CEMETERY OR CREMATORY OLDTOWN M.E. CEMETERY		22d. LOCATION (City, town, or county) (State) OLDTOWN, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Baltimore, Md.		24a. REC'D BY REGISTRAR Oct 31 '61	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hines		DATE SIGNED Oct 28 1961	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW YORK STATE
DEPARTMENT OF HEALTH

14

1912

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1900

[Faint, mostly illegible text and markings on a form, likely a medical certificate or death record. The text is mirrored and difficult to decipher.]

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10913 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10905

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
c. LENGTH OF STAY IN 1b 1 year				d. STREET ADDRESS 93 Henderson Blvd			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 93 Henderson Blvd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Harrison Isles, Jr.				4. DATE OF DEATH Month October Day 30 Year 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 10/24/1916	
9. AGE (In years last birthday) 45 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Keyser, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Misc.			
13. FATHER'S NAME John Harrison Isles, Sr.				14. MOTHER'S MAIDEN NAME Charlotte Mae Kesecker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes World War II				16. SOCIAL SECURITY NO. 557-26-4294			
17. INFORMANT Mrs. Harry Cole, Mother- McCoole, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO CORONARY SCLEROSIS WITH THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1-2 Hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED October 30, 1961			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/1/61		22c. NAME OF CEMETERY OR CREMATORY Queens Point Cemetery		22d. LOCATION (City, town, or country) (State) Keyser, W. Virginia	
23. FUNERAL DIRECTOR John F. Hyler Cumberland Md.				24a. REC'D BY REGISTRAR NOV 1 '61			
				24b. REGISTRAR'S SIGNATURE Arthur L. Huns			

10001

10016

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1

Handwritten signature and text at the bottom of the page, including "John F. St. John" and "St. John's University".

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G299 11/3/61 iwk

10914

CERTIFICATE OF DEATH

Reg. Dist. No. **10906**

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>4 yrs., 8 mos.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sylvan Retreat</u>				d. STREET ADDRESS <u>Queen City Pavement</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harrison</u> <u>Jordan</u>				4. DATE OF DEATH Month Day Year <u>October</u> <u>27</u> <u>19 61</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>April 19, 1896</u>		9. AGE (In years last birthday) yrs. <u>65</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (Ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Contracting</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles Jordan</u>						14. MOTHER'S MAIDEN NAME <u>Jeanette Shears</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Edward H. Jordan, Cresaptown, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerosis, with</u> DUE TO (c) <u>Cerebral degeneration</u>										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>61</u> , to <u>October 27</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>October 26</u> , 19 <u>61</u> , and that death occurred at <u>1:30 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED													
ACTUAL SIGNATURE <u>R. Mathews</u> M.D.													
PHYSICIAN'S NAME (Type) <u>L. B. Mathews, M.D.</u> <u>49 Greene Street, Cumberland, Md.</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Oct. 29, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u> <u>Cumberland, Md.</u>						24a. REC'D BY REGISTRAR DATE <u>OCT 31 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10516

10008

PLACE OF BIRTH _____		RACE _____	
SEX _____		DATE OF BIRTH _____	
PLACE OF DEATH _____		DATE OF DEATH _____	
TIME OF DEATH _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____	
NAME OF DECEASED _____		NAME OF PHYSICIAN _____	
ADDRESS OF DECEASED _____		ADDRESS OF PHYSICIAN _____	
CITY OF DECEASED _____		CITY OF PHYSICIAN _____	
STATE OF DECEASED _____		STATE OF PHYSICIAN _____	
COUNTY OF DECEASED _____		COUNTY OF PHYSICIAN _____	
ZIP CODE OF DECEASED _____		ZIP CODE OF PHYSICIAN _____	
NAME OF FUNERAL HOME _____		NAME OF BURIAL PLACE _____	
ADDRESS OF FUNERAL HOME _____		ADDRESS OF BURIAL PLACE _____	
CITY OF FUNERAL HOME _____		CITY OF BURIAL PLACE _____	
STATE OF FUNERAL HOME _____		STATE OF BURIAL PLACE _____	
COUNTY OF FUNERAL HOME _____		COUNTY OF BURIAL PLACE _____	
ZIP CODE OF FUNERAL HOME _____		ZIP CODE OF BURIAL PLACE _____	
NAME OF NEXT OF KIN _____		NAME OF SURVIVOR _____	
ADDRESS OF NEXT OF KIN _____		ADDRESS OF SURVIVOR _____	
CITY OF NEXT OF KIN _____		CITY OF SURVIVOR _____	
STATE OF NEXT OF KIN _____		STATE OF SURVIVOR _____	
COUNTY OF NEXT OF KIN _____		COUNTY OF SURVIVOR _____	
ZIP CODE OF NEXT OF KIN _____		ZIP CODE OF SURVIVOR _____	
NAME OF WITNESS _____		NAME OF WITNESS _____	
ADDRESS OF WITNESS _____		ADDRESS OF WITNESS _____	
CITY OF WITNESS _____		CITY OF WITNESS _____	
STATE OF WITNESS _____		STATE OF WITNESS _____	
COUNTY OF WITNESS _____		COUNTY OF WITNESS _____	
ZIP CODE OF WITNESS _____		ZIP CODE OF WITNESS _____	

10915

10907

1. PLACE OF DEATH a. COUNTY Alberta Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN lb 60 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		43	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 332 Front St.				d. STREET ADDRESS 332 Front		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alberta Frances Korns		First Middle Last		4. DATE OF DEATH Oct. 20 19 61		Month Day Year	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 13, 1874	
9. AGE (In years last birthday) yrs. 86		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T. McIntosh		14. MOTHER'S MAIDEN NAME Sarah F. Coleman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Kenneth Scheaffer-Westernport, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 792X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Circulatory Failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 2 mos		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1 1961 to Oct 20 1961 , that (I) (we) last saw the deceased alive on 10-19 1961 , and that death occurred at 3:38 M, from the causes and on the date stated above.							
22a. SIGNATURE Robert W. Bess, M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. ADDRESS Piedmont, W. Va.		22c. DATE SIGNED 10-21-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/23/61		23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City, town, or county) (State) Westernport Md.	
24. FUNERAL DIRECTOR'S SIGNATURE E. L. Bess		ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE 24 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Fraw	

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THE WHITE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10916

10908

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 402 Louisiana Ave.				e. STREET ADDRESS / 402 Louisiana Ave			
3. NAME OF DECEASED (Type or print) RALPH LEO KETZNER				4. DATE OF DEATH October 2 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1889	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Car Distributor B. & O. Rwy				11. BIRTHPLACE (County & State, or foreign country) Jefferson Cty. W. Va. U. S. A.			
13. FATHER'S NAME John Ketzner				14. MOTHER'S MAIDEN NAME Georgianna Forney			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. Mrs. Ralph Ketzner 402 Louisiana Ave.			
17. INFORMANT Cumb. Md.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis 331X DUE TO Cerebral Haemorrhage c Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Left Hemiplegia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				INTERVAL BETWEEN ONSET AND DEATH 3 hrs 2 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1959 to Oct 2, 1961 that (I) (we) last saw the deceased alive on Oct 1, 1961 , and that death occurred at 10/3/61 M, from the causes and on the date stated above.							
22a. SIGNATURE Clay Durrett M.D.				22b. DATE SIGNED 10/3/61			
22c. PHYSICIAN'S NAME (Type) Clay Durrett M. D.				22d. ADDRESS 236 Virginia Ave. Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/5/61		23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, Cumberland, Md.				25a. REC'D BY REGISTRAR Oct 5 '61			
				25b. REGISTRAR'S SIGNATURE Clayton S. Kline			

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXERCISED WITHIN 24 HOURS AFTER DEATH. PAGE 4 MAY BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. TO FUNERAL DIRECTOR: AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN BY THE FUNERAL DIRECTOR, PAGE 3 SHOULD BE DETACHED FOR USE AS THE BURIAL-TRANSIT PERMIT. THEN PLEASE REMOVE CARBON PAPERS. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPT. OF HEALTH PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT, WITHIN 72 HOURS AFTER DEATH.

VR A15 (4)
15M 9/60

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1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10917 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10909

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 1 Hr.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westernport		43	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miners Hospital				d. STREET ADDRESS 226 Smoot St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Barbara Ellen Kidwell				4. DATE OF DEATH Oct 6 1961		Month Oct Day 6 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 29, 1944	9. AGE (In years last birthday) 17 yrs.	IF UNDER 1 YEAR Months 0 Days 6	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY High School		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Denzel Kidwell				14. MOTHER'S MAIDEN NAME Wilda V. Arnold			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes give war or date of service)		17. INFORMANT Address Wilda V. Kelly-Westernport, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACRANIAL HEMORRHAGE 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) MACERATION OF BRAIN (c) SKULL FRACTURE						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 Hrs. 1 1/2 Hrs. 1 1/2 Hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident -					
20c. TIME OF INJURY Month, Day, Year 10:30 a.m. Oct 6 1961		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Longsawing Allegany Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W O McLane		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) W O McLane M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Frostburg Md		10/6/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/9/61		22c. NAME OF CEMETERY OR CREMATORY Philos		22d. LOCATION (City, town, or county) (State) Westernport Md.	
23. FUNERAL DIRECTOR ADDRESS El Boal Westernport, Md.				24a. REC'D BY REGISTRAR OCT 10 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hanes	

MEDICAL CERTIFICATION

512

1290

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10918

CERTIFICATE OF DEATH

10910

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 2 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RAWLINGS d. STREET ADDRESS Along U. S. Rt. # 220 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) ELIZABETH KUYKENDALL First Middle Last				4. DATE OF DEATH OCT. 23 19 61 Month Day Year									
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 19, 1878		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or (foreign country) Springfield, W. Va.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME John Barnes						14. MOTHER'S MAIDEN NAME * * * * * Florence Woodrow							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. William Dixon, Rawlings, Md. Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 725X Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension DUE TO (c) hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												INTERVAL BETWEEN ONSET AND DEATH weeks years days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from Oct 21, 1961 to Oct 23, 1961 , that (I) (we) last saw the deceased alive on Oct 22, 1961 and that death occurred at 11 M, from the causes and on the date stated above.													
22a. SIGNATURE Blane M. Schindler M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/23/61		22c. PHYSICIAN'S NAME (Type) BLANE M. SCHINDLER, M.D.		22d. ADDRESS # 43 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial				23b. DATE THEREOF 10/25/61		23c. NAME OF CEMETERY OR CREMATORY Biertown Cem.				23d. LOCATION (City, town or county) Nr. Rawlings, Maryland (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George ADDRESS Cumberland, Md.						25a. REC'D BY REGISTRAR OCT 25 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hume					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10915 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10914

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>47 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>432 Seymour St.</u>				d. STREET ADDRESS <u>432 Seymour St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John</u> <u>Levi</u> <u>Lear</u>				4. DATE OF DEATH Month Day Year <u>Oct.</u> <u>17</u> <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 12, 1914</u>		9. AGE (in years last birthday) <u>47</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Extrusion Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Textile Industry</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>			
13. FATHER'S NAME <u>Ross C. Lear</u>				14. MOTHER'S MAIDEN NAME <u>Pearl May</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-07-3371</u>		17. INFORMANT Address <u>Mrs. Ada Lear, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GUNSHOT OF HEAD</u> DUE TO <u>(SELF INFLICTED)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>October 17, 1961</u>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Cumberland, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-20-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>		ADDRESS <u>James F. Scarpelli, Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 23 '61</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>		24c. LOCATION (City, town, or county) (State) <u>Near Confluence, Pa.</u>					

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10920

CERTIFICATE OF DEATH

10912

1. PLACE OF DEATH e. COUNTY <u>ALLEGANY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u> c. LENGTH OF STAY IN 1b <u>22 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SACRED HEART HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u> d. STREET ADDRESS <u>320 WAVERLY TERRACE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>Ausburn</u> Last <u>LEASURE</u>		4. DATE OF DEATH Month <u>10</u> Day <u>3</u> Year <u>1961</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/22/1886</u>		9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR: Months <u>3</u> Days <u>19</u> IF UNDER 24 HRS.: Hours <u>19</u> Min. <u>19</u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Desk Clerk -</u>				11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>DANIEL LEASURE</u>				14. MOTHER'S MAIDEN NAME <u>MARY VIRGINIA LEASURE Hoffman</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>220-10-8579</u> 17. INFORMANT <u>CHART</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 493X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Chronic Tuberculosis arrested</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY: Month, Day, Year <u>19</u> Hour e.m. _____ p.m. _____ 20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____													
21. I certify that (I) (this hospital) attended the deceased from <u>7/11</u> , 19 <u>61</u> , to <u>10/3</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10/2</u> , 19 <u>61</u> , and that death occurred at <u>10/3</u> , M, from the causes and on the date stated above.													
22a. SIGNATURE <u>Leo H. Ley, Jr.</u> M.D.						22b. DATE SIGNED <u>10/3/61</u>							
22c. PHYSICIAN'S NAME (Type) <u>DR. LEO LEY, JR.</u>						22d. ADDRESS <u>456 NORTH CENTRE STREET</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10/6/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>				24. ADDRESS <u>Cumberland, Maryland</u>				25a. REC'D BY REGISTRAR <u>OCT 4 '61</u>					
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>				25c. DATE <u>10/3/61</u>				25d. TIME <u>10/3/61</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

81001

09001



CERTIFICATE OF DEATH

10913

Reg. Dist. No.

10921

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport Cumberland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kookon Nursing Home			d. STREET ADDRESS 437 Walnut Harrison St.		
3. NAME OF DECEASED (Type or print) First Clara Middle Rebecca Last Liller			4. DATE OF DEATH Month Oct. Day 1 Year 1961		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 6, 1874	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 1 Days 25 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) New Creek, W.Va.	
13. FATHER'S NAME William Henry Bobo			14. MOTHER'S MAIDEN NAME Harrett Metcalf		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Frank Kookon, Westernport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-renal disease 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Senility					INTERVAL BETWEEN ONSET AND DEATH 2 yrs 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June , 19 57 , to Oct. 1 , 19 61 , that I last saw the deceased alive on Sept 30 , 19 61 , and that death occurred at 7:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Piedmont, W.Va. DATE SIGNED 10-3-61					
ACTUAL SIGNATURE <i>James H. Wolverton</i>		PHYSICIAN'S NAME (Type) James H. Wolverton M.D. Piedmont, W.Va.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-1-61		22c. NAME OF CEMETERY OR CREMATORY Queen's Point Cem.	
22d. LOCATION (City, town, or county) Keyser, W.Va.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Thomas Smith Jr</i>		ADDRESS Keyser W.Va.		24a. REC'D BY REGISTRAR OCT 4 '61	
24b. REGISTRAR'S SIGNATURE <i>Charles S. Evans</i>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10922

CERTIFICATE OF DEATH

10914

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG c. LENGTH OF STAY IN 1b 10 HRS. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG, d. STREET ADDRESS RT. 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MILTON B. LOHR				4. DATE OF DEATH Month OCTOBER Day 16 Year 1961					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 28, 1883		9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FIREMAN				10b. KIND OF BUSINESS OR INDUSTRY BRICK YARD		11. BIRTHPLACE (County & State, or foreign country) GARRETT COUNTY, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB LOHR				14. MOTHER'S MAIDEN NAME CATHERINE RALEY					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-10-6344		17. INFORMANT Address MRS. RHODA LOAR, RT. 2, FROSTBURG, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Coronary occlusion. (b) Arterio-sclerotic Cardio-vascular disease (c) 3-4 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								INTERVAL BETWEEN ONSET AND DEATH 12 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10-15 to 10-16 , 19 61 , that (I) (we) last saw the deceased alive on 10-16 , 19 61 , and that death occurred 3:15 P.M. from the causes and on the date stated above.									
22a. SIGNATURE H. C. Diehl				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 39 W. MAIN ST., FROSTBURG, MD.		22b. DATE SIGNED 10/16/61			
22c. PHYSICIAN'S NAME (Type) H. C. DIEHL, M.D.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-18-1961		23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK		23d. LOCATION (City, town or county) (State) FROSTBURG, MD.			
24. FUNERAL DIRECTOR'S SIGNATURE J. R. Burst				25a. REC'D BY REGISTRAR DATE OCT 19 '61		25b. REGISTRAR'S SIGNATURE Charles S. Hines			

MEDICAL CERTIFICATION

TO SPECIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10923

CERTIFICATE OF DEATH

10915

Item 8 Film G297 10/20/61 iwk

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND d. STREET ADDRESS 614 N. MECHANIC STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) IRENE PEARL LONG		4. DATE OF DEATH Month Day Year OCTOBER 13, 1961		5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/14/1887		9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home				11. BIRTHPLACE (County & State, or foreign country) Great Capeon V. Va				12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME John Stonebaugh				14. MOTHER'S MAIDEN NAME (Unknown) Farris				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. PT'S CHART			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Congestive Heart Failure												18. INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.															
22a. SIGNATURE Leo M. Ley, Jr.				22b. DATE SIGNED 10/17/61				22c. PHYSICIAN'S NAME (Type) DR. LEO. LEY				22d. ADDRESS 456 N. CENTRE ST. CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF 10/17/61				23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem. Cumb., Md.				23d. LOCATION (City, town or county) (State) Cumb., Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				24b. ADDRESS Cumb., Md.				25a. REC'D BY REGISTRAR DATE OCT 17 '61				25b. REGISTRAR'S SIGNATURE Arthur L. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

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OLIVER W. BROWN
(Chairman) 10010

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(Chairman) 10010

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OLIVER W. BROWN
(Chairman) 10010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10924					10917				
1. PLACE OF DEATH a. COUNTY ALLEGANY					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 34 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL					d. STREET ADDRESS 749 MARYLAND AVE.			a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR VAUGHN MCFARLAND					4. DATE OF DEATH Month Day Year OCT. 31 19 61				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 6, 1896		9. AGE (In years last birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROAD				11b. KIND OF BUSINESS OR INDUSTRY WEST VIRGINIA				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME GEORGE MCFARLAND (DECEASED)					14. MOTHER'S MAIDEN NAME MARGARET CHRISMORE (DECEASED)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO. INFORMANT				
17. PATIENT'S CHART									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis 443X DUE TO (b) myocarditis & decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Hypertension								INTERVAL BETWEEN ONSET AND DEATH 3 mths 2 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 1954 to Oct. 31, 1961 , that (I) (we) last saw the deceased alive on Oct 31, 1961 , and that death occurred at 11:15 M, from the causes and on the date stated above.									
22a. SIGNATURE Clayton Durrett M.D.					22b. DATE SIGNED 11/1/61				
22c. PHYSICIAN'S NAME (Type) CLAY DURRETT, M.D.					22d. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Nov. 3, 61		23c. NAME OF CEMETERY OR CREMATORY Prosperity Cemetery		23d. LOCATION (City, town or county) (State) near Cumberland Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Service					25a. REC'D BY REGISTRAR NOV 6 '61				
					25b. REGISTRAR'S SIGNATURE Arthur L. K...				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10925

10918

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage</u> c. LENGTH OF STAY IN 1b <u>Lifetime</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Foundry Row</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage</u> d. STREET ADDRESS <u>Foundry Row</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HUGH J. MCKENZIE</u>				4. DATE OF DEATH <u>October 8th 1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-21-01</u>	
9. AGE (In years if UNDER 1 YEAR, if UNDER 24 HRS. last birthday) <u>60</u> yrs.		Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.		10. BIRTHPLACE (County & State, or foreign country) <u>Greenville Township</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner (retired)</u>				12b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mines</u>			
13. FATHER'S NAME <u>Joshua McKenzie</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Arklie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>213-01-4657</u>			
17. INFORMANT <u>Mrs. Billy Timney, R.D. #1 (Barton)</u>				Address <u>Frostburg, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Heart Disease</u> <u>260X</u> DUE TO (b) <u>Coronary Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Diabetes mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>undulant</u> <u>6 yrs?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>X</u>			
20c. TIME OF INJURY Hour e.m. <u>X</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>X</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1959</u> to <u>10/8/61</u> , that (I) (we) last saw the deceased alive on <u>10/8/61</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Martin M. Rothstein, M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/10/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARTIN M. ROTHSTEIN, M.D.</u>				22d. ADDRESS <u>48 BROADWAY - FROSTBURG, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-11-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Mt. Savage Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Beulah H. Whitesant</u>				25a. REC'D BY REGISTRAR <u>OCT 13 '61</u>			
ADDRESS <u>23 E. Main, Frostburg, Md.</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10919

10926

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b X Lonaconing			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS Detmold Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle DEWEY Last METTS				4. DATE OF DEATH Month 10/3/1961 Day 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/15/1898	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 62 Hours 62 Min.		IF UNDER 24 HRS. Months 62 Days 62 Hours 62 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY Garrett, County		11. BIRTHPLACE (State or foreign country) U.S.A	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME John H. Metts				14. MOTHER'S MAIDEN NAME Sarah Teeters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Anna Metts, Lonaconing, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral vascular accident (c) Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 9 days years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Jan. 1956 to Oct. 1961				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan. 1956 to Oct. 1961 , that (I) (we) last saw the deceased alive on Oct 2 1961 , and that death occurred at 9 a.m. from the causes and on the date stated above.							
22a. SIGNATURE L.R. Miles, Jr.				M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10.5.61	
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.				22d. ADDRESS LONA CONING MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/6/1961		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION (City, town, or county) (State) Moscow, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN				ADDRESS LONA CONING, MD.		25a. REC'D BY REGISTRAR DATE OCT 9 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hars...			

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MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY		ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		MARYLAND		b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		CUMBERLAND		c. LENGTH OF STAY IN b		LIFE		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		536 VALLEY STREET"		d. STREET ADDRESS		536 VALLEY STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		RUTH		G.		METZ		4. DATE OF DEATH		OCT. 4, 19 61	
5. SEX		FEMALE		6. COLOR OR RACE		WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		TAVERN OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY		SELF		9. AGE (In years last birthday)		43 42 yrs.	
11. BIRTHPLACE (State or foreign country)		MARYLAND		12. CITIZEN OF WHAT COUNTRY?		USA		13. FATHER'S NAME		ZEDDICK MASON CLARK	
14. MOTHER'S MAIDEN NAME		BEULAH CLARK		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		NO		16. SOCIAL SECURITY NO.		220 07 6476	
17. INFORMANT		BARBARA ANN SHAW		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CORONARY OCCLUSION, LEFT		INTERVAL BETWEEN ONSET AND DEATH		# 3-4 Hrs.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		CUMBERLAND		20g. (County)		CUMBERLAND		20h. (State)		CUMBERLAND	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		21. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		21. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
21. ACTUAL SIGNATURE		Benedict Skitarelic		21. EXAMINER'S NAME (Type)		BENEDICT SKITARELIC, M.D.		21. Address (Street, city, town, or county)		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		BURIAL		22b. DATE THEREOF		OCT. 7, 1961		22c. NAME OF CEMETERY OR CREMATORY		GREENMOUNT CEMETERY	
22d. LOCATION (City, town, or country)		CUMBERLAND		22e. ADDRESS		CUMBERLAND, MD.		23. FUNERAL DIRECTOR		BYRON KIGHT	
24a. REC'D BY REGISTRAR		OCT 10 '61		24b. REGISTRAR'S SIGNATURE		Charles S. Krome		24c. REGISTRAR'S NAME		Charles S. Krome	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10928

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G299 11/1/61 ink

Reg. Dist. No.

10921

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 147 WOOD ST.		d. STREET ADDRESS 147 WOOD ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DUANE Middle GIRARD Last MORAN		4. DATE OF DEATH Month OCTOBER Day 23 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 21, 1961
9. AGE (In years last birthday) 6 yrs. 6 mos. 28 days		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OR WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT MORAN		14. MOTHER'S MAIDEN NAME ELAINE HESS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NONE		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT ROBT. MORAN, 147 WOOD ST., FROSTBURG, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation DUE TO 924.0 Conditions, if any, which gave rise to immediate cause (b) Infant (c) Wrapped Head in Blanket & Suffocated DUE TO 5-8 min INTERVAL BETWEEN ONSET AND DEATH 5-8 min		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or, Part II of item 18.) Infant Wrapped Head in Blanket & Suffocated	
20c. TIME OF INJURY Month, Day, Year Oct 23 1961 Hour a.m. 10:30	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Frostburg Allegany Md
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W O M C Lane		DATE SIGNED Oct 24 1961	
EXAMINER'S NAME (Type) W. O. MC LANE, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10-26-61	22c. NAME OF CEMETERY OR CREMATORY ST. PATRICK'S CEMETERY	22d. LOCATION (City, town, or county) (State) MT. SAVAGE, MD.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst		24a. REC'D BY REGISTRAR Oct 26 '61	
ADDRESS FROSTBURG, MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10929 CERTIFICATE OF DEATH 10922											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MA WEST VIRGINIA b. COUNTY MINERAL ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL RIDGELEY d. STREET ADDRESS					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND						c. LENGTH OF STAY IN 1b 3 days					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last			4. DATE OF DEATH Month Day Year			5. SEX MALE			6. COLOR OR RACE WHITE		
BENJAMIN FRANKLIN MURRAY			10 20 19 61			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Jan 2, 1884		
9. AGE (In years last birthday) 77 yrs.			IF UNDER 1 YEAR Months Days			IF UNDER 24 HRS. Hours Min.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assemblyman		
11. PLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME JOHN HENRY MURRAY			14. MOTHER'S MAIDEN NAME MARIE SUSAN ARNOLD		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 232-03-0566			17. INFORMANT CHART			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive V. Disease (c) Senilized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I INTERVAL BETWEEN ONSET AND DEATH days year year											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from January 19, 1956 to 10/20/61 , that (I) (we) last saw the deceased alive on 10/19/61 , and that death occurred at 10/20/61 M, from the causes and on the date stated above.											
22a. SIGNATURE B. M. Schindler						22b. DATE SIGNED 10/20/61			22c. PHYSICIAN'S NAME (Type) DR. B.M. SCHINDLER		
22d. ADDRESS 43 GREENE STREET						23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
23b. DATE THEREOF Oct. 22, 1961						23c. NAME OF CEMETERY OR CREMATORY Rosh Hill Cemetery					
23d. LOCATION (City, town or county) (State) Cumberland, Md.						24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, 202 Greene St. Maryland					
25a. REC'D BY REGISTRAR OCT 23 '61						25b. REGISTRAR'S SIGNATURE Arthur S. Hines					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10930 CERTIFICATE OF DEATH 10923											
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg						c. LENGTH OF STAY IN 1b Lifetime					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 62 West College Avenue						d. STREET ADDRESS 62 West College Avenue					
3. NAME OF DECEASED (Type or print) ANNIE ELIZABETH ORT						4. DATE OF DEATH 10 27th 1961					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-1-1875		9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (County & State, or foreign country) Frostburg, Md.		
12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME Martin Hartig						14. MOTHER'S MAIDEN NAME Catherine Dilfer					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Alice Scoggan, 62 W. College, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) X					
20c. TIME OF INJURY Hour a.m. p.m. X 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X		20f. (City or town) X		20g. (County) X		20h. (State) X	
21. I certify that (I) (this hospital) attended the deceased from AUGUST , 19 60 to OCT. 27 , 19 61 , that (I) (I) last saw the deceased alive on OCT. 27, 1961 , and that death occurred at 3 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Martin M. Rothstein M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/28/61			
22c. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN M.D.						22d. ADDRESS 48 BROADWAY - FROSTBURG - MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-29-61		23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park, Frostburg		23d. LOCATION (City, town or county) Frostburg		23e. (State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Beulah H. Montesano						25a. REC'D BY REGISTRAR NOV 1 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

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Dr. J. M. Smith

DATE: 11/11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 32 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before at a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LA VALE d. STREET ADDRESS 61 LA VALE BOULEVARD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RUTH Middle V. Last PLUMMER		4. DATE OF DEATH Month OCTOBER Day 11 Year 19 61					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 27, 1904	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months 56 Days 11 Hours 19 Min. 61		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Country, State, or foreign country) MARYLAND			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ALBERT PLUMMER		14. MOTHER'S MAIDEN NAME MAUDE RICHARDS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 526x DUE TO Terminal Cardiac Failure Conditions, if any, which gave rise to immediate cause (b) Cor Pulmonale (c) DUE TO Chronic Bronchitis, Bronchiectasis, Pulmonary Phrosis cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 2 month 1 year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1933 to 11 Oct 61 , that (I) (we) last saw the deceased alive on 10 Oct 1961 , and that death occurred at 1:40 A.M. from the causes and on the date stated above.							
22a. SIGNATURE W. Alfred Van Ormer M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 17 Oct 61			
22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		22d. ADDRESS 122 S. CENTRE STREET, CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-13-61		23c. NAME OF CEMETERY OR CREMATORY F'B.G. MEMORIAL PARK			
23d. LOCATION (City, town or county) FROSTBURG,		23e. REC'D BY REGISTRAR OCT 16 '61		23f. REGISTRAR'S SIGNATURE Arthur L. Hume			
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Durst		ADDRESS FROSTBURG, MD.					



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ALLIANT

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32 DAYS

LA WILE

MEMORIAL HOSPITAL

OF LA WILE HOSPITAL

RUTH

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OCTOBER 11

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FEMALE WHITE

NOV. 27, 1934

HOPE

MARYLAND

U.S.A.

ALBERT FLUMER

MADE RICHARDS

MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

DR. W. A. VAN CREEP

122 S. CENTRE STREET, CUMBERLAND, MD.

HUBIAL

10-13-31

THIRD MEMORIAL TANK

WESTBURY

PROSTBURG, MD.

Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10932

10925

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 6 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS 175 FIRST STREET	
3. NAME OF DECEASED (Type or print) JOHN THOMAS RANKIN		4. DATE OF DEATH OCTOBER 29TH, 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 9TH, 1917
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE AGENT		10b. KIND OF BUSINESS OR INDUSTRY LIFE INSURANCE	11. BIRTHPLACE (County & State, or foreign country) FROSTBURG
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CLAYTON RANKIN	
14. MOTHER'S MAIDEN NAME PEARL CHANEY		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES	
16. SOCIAL SECURITY NO. 214-07-6752		17. INFORMANT MRS. MARY RANKIN, 175 FIRST ST. F'BG. MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X Post-Operative Cardiac Failure DUE TO (b) Abdominal Perineal Resection DUE TO (c) Carcinoma of rectum PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 20, 1961 to Oct 29, 1961 that (I) (we) last saw the deceased alive on Oct 29, 1961 and that death occurred at 11 M, from the causes and on the date stated above.			
22a. SIGNATURE S. E. ENFIELD		22b. DATE SIGNED Oct 30-61	
22c. PHYSICIAN'S NAME (Type) S. E. ENFIELD		22d. ADDRESS ELLERSLIE ROAD, CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/31/61	23c. NAME OF CEMETERY OR CREMATORY F'BG. MEMORIAL PARK	23d. LOCATION (City, town or county) (State) FROSTBURG, MD.
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Hurst		25. REC'D BY REGISTRAR NOV 1 '61	
ADDRESS FROSTBURG, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Haines	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10926**

10933

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN lb Lifetime			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Memorial Hospital				d. STREET ADDRESS 407 Central Avenue			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last RHODES				4. DATE OF DEATH Month October Day 9 Year 19 61			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1922		9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months 02 Days 1	IF UNDER 24 HRS. Hours 1 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Odd Jobs		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Mary Jane Rhodes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 215-16-4334		17. INFORMANT Address Ruth Rhodes, Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY THROMBOSIS DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Fatty Liver							INTERVAL BETWEEN ONSET AND DEATH Sudden Sudden
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelis, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/11/61		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE OCT 11 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10934

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10927

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 HRS. 55 MIN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONA CONING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS WATERCLIFF ST.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RIVENBARK		4. DATE OF DEATH Month OCTOBER Day 10 Year 19 61			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 10, 1961	9. AGE (In years last birthday) yrs. 2	IF UNDER 1 YEAR Months 2 Days 22
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID C. RIVENBARK		14. MOTHER'S MAIDEN NAME MATILDA O'ROURKE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) Failure of All Vital Functions DUE TO (c) Previab. Prematurity				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred 9:55 AM from the causes and on the date stated above.					
22a. SIGNATURE Leland Ransom		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10 OCT 61	
22c. PHYSICIAN'S NAME (Type) LELAND RANSOM		22d. ADDRESS 63 GREENE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/10/1961		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery	
				23d. LOCATION (City, town or county) (State) Lonaconing, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN		ADDRESS LONA CONING, MD.		25a. REC'D BY REGISTRAR DATE OCT 13 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Ransom	

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CONCERNING

S. HISS, EX-MIN.

CHURCHLAND

WATERLOO ST.

MEMORIAL HOSPITAL

OCTOBER 10, 1961

RIVERBARK

OCTOBER 10, 1961

WHITE

U.S.A.

CHURCHLAND, WYAND

MILWAUKEE

DAVID C. RIVERBARK

CHURCHLAND, MO.

MEMORIAL HOSPITAL

MO.

MO.

*Value of the stock transfer
is \$100.00*

9:55 AM

10:00 AM

63 GREENE ST., CHURCHLAND, MO.

LELAND BAWSON

DAVID 1961

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FOR STATE
HEALTH DEPT.

1
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND

10935 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10928

Item 8 Film G299 11/3/61 iwk

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XXXX Irons Mountain		d. STREET ADDRESS R.F.D. 4		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Millard Alvin Robinette		4. DATE OF DEATH Month Day Year Oct. 28 1961		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1898 Oct. 23, 1961/63		9. AGE (In years last birthday) yrs. Months Days 63	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Irons Mountain, Md.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Robinette		14. MOTHER'S MAIDEN NAME Laura B. Valentine		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Address George Tedrick, Cumberland, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION, MASSIVE 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) CORONARY SCLEROSIS WITH OCCLUSION (c) DUE TO (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Old --		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
21. ACTUAL SIGNATURE Benedict Skitarelic		21. M.D. BENEDICT SKITARELIC, M.D.		21. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		21. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		21. DATE SIGNED October 28, 1961		21. Address (Street, city, town, or county)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 10-31-1961		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or country) Cumberland, Md.		22e. (State) Md.		23. FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR OCT 31 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO LOCALITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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George Hart, Jr., President of the

Medical Department, Hospital

CONVULSIONS WITH SCISSORING

October 28, 1901

REPORT OF THE

10032

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10936

10929

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 4 DAYS			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 15 MARKET ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last FLORENCE ERMA SCHARF			4. DATE OF DEATH Month Day Year OCT. 17 19 61		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 21, 1891		9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME SAMUEL BARRETT (DECEASED)			14. MOTHER'S MAIDEN NAME EMMA (NOT KNOWN) (DECEASED)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT PATIENT'S CHART		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic and hypertensive cardiovascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 weeks 7 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 12-4 , 19 61 to 10-17 , 19 61 , that (I) (we) last saw the deceased alive on 10-17 , 19 61 and that death occurred at 2p.M. from the causes and on the date stated above.					
22a. SIGNATURE <i>Ralph W. Ballin</i> M.D.			22b. DATE SIGNED 10-19-61		
22c. PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.			22d. ADDRESS 62 Greene St. Cumberland, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/20/61	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Cumberland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox			25a. REC'D BY REGISTRAR OCT 23 '61		
ADDRESS Cumberland Maryland			25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>		

MEDICAL CERTIFICATION

TO HEALTH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-15-83 BY SP-6 JRS/STW

DATE 10-15-83 BY SP-6 JRS/STW

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10937					10930						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY Allegany					a. STATE Maryland b. COUNTY Allegany						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rt. 1, Frostburg					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rt. 1, Frostburg,						
c. LENGTH OF STAY IN lb 20 Yrs.					d. STREET ADDRESS						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED			First		Middle		Last		4. DATE OF DEATH		
(Type or print)			Cora		Etta		Silber		Month October Day 5th Year 19 61		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH July 31st, 1890		9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own housework		11. BIRTHPLACE (County & State, or foreign country) West Virginia				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Franklin Bennett					14. MOTHER'S MAIDEN NAME Rebecca Teter					Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 234-26-7034A					16. SOCIAL SECURITY NO. 0tta Silber, Rt, 1, Frostburg, Md.					17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Generalized arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 4-3- 19 61 , to 10-5- 19 61 , that (I) (we) last saw the deceased alive on 9-30 19 61 , and that death occurred at 10-5-61 M, from the causes and on the date stated above.										22b. DATE SIGNED	
22a. SIGNATURE L. Brings					M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		10-5-61		
22c. PHYSICIAN'S NAME (Type) Lewis Brings,					" 57 Greene Street, Cumberland, Md.		22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10-7-61		23c. NAME OF CEMETERY OR CREMATORY Flanagan Hill Cemetery,			23d. LOCATION (City, town or county) (State) Red Creek, W. Va.			
24 FUNERAL DIRECTOR'S SIGNATURE Joseph R. Rust					ADDRESS Frostburg, Md.		25a. REC'D BY REGISTRAR OCT 9 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Huns		

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2yr, 1mo, 22da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mildred Middle Estella Last Sleeman		4. DATE OF DEATH Month October Day 4 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 27th, 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Housework	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME George Henry		14. MOTHER'S MAIDEN NAME Delphine Ross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-10-4389A	
17. INFORMANT Mrs. Alma Davis, Rt. 1, Frostburg, Md.		Address Box 345	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial degeneration, Senile 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis, Senile DUE TO (c) Senility with psychotic features (7:1)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1961 to October 4, 1961 , that I last saw the deceased alive on October 3, 1961 , and that death occurred at 10:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE L. B. Mathews		M.D.	
PHYSICIAN'S NAME (Type) L. B. Mathews, M.D.		49 Greene Street, Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-6-1961	22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. P. Duvall		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR ACT 9 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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WILLIAM BROWN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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10939

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10932

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 1 HR. 1 MIN. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND d. STREET ADDRESS 1 895 MC MULLEN HIGHWAY e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BABY GIRL SMITH		4. DATE OF DEATH OCTOBER 5, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 5, 1961
9. AGE (In years, last birthday) 7573		10. IF UNDER 1 YEAR: Months 1 Days 1 Hours 1 Min. 1	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HOWARD D. SMITH		14. MOTHER'S MAIDEN NAME CARMEN C. CHAPELA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT RM MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 7573 DUE TO Vascular abnormality - congenital Ductus communis - Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Edema - Polyhydramnios PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 hr 1 min.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 5 to Oct 5 , that (I) (we) last saw the deceased alive on Oct 5 , 19 61 , and that death occurred at 6:00 PM from the causes and on the date stated above.			
22a. SIGNATURE W. Royce Hodges		22b. DATE SIGNED 10/6/61	
22c. PHYSICIAN'S NAME (Type) DR. W. ROYCE HODGES		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/6/61	
23c. NAME OF CEMETERY OR CREMATORY Queens Point Cemetery		23d. LOCATION (City, town or county) (State) Keyser, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, Cumberland, Md.		25a. REC'D BY REGISTRAR OCT 9 '61	
25b. REGISTRAR'S SIGNATURE Charles L. Thomas			

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WARWICK & LUTHER AVENUES
HOSPITAL

500 MC NUTTEN HIGHWAY

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OCTOBER 2, 1961

SMITH

CHILD

BABY

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OCTOBER 2, 1961

Female White

U. S. A.

CUMBERLAND, MD.

Female

CARMEN C. CHARLIS

HOWARD D. SMITH

DR MEMORIAL HOSPITAL - CUMBERLAND, MD.

Female

Female

2:00 PM

1/1/61

122 S. CENTRE ST., CUMBERLAND, MD.

DR. W. ROYCE HODGES

1/1/61
L. Wayne George, Cumberland, Md., M.D.
L. Wayne George, Cumberland, Md., M.D.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10940 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10933

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b Found Dead in Car d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Found Dead in Car		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 408 Decatur St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Howard M. Spiker		4. DATE OF DEATH Last Month Day Year October 18, 1961 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Realtor		10b. KIND OF BUSINESS OR INDUSTRY Real Estate & Insurance	
11. BIRTHPLACE (State or foreign country) Dobin, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas J. Spiker		14. MOTHER'S MAIDEN NAME Rebecca McKimney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW 1		16. SOCIAL SECURITY NO. 220-10-1584	
17. INFORMANT Mrs. Bessie A. Hanks		Address Cumberland, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Sclerosis (c) Sudden PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 21, 1961	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or country) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR Louis Stain Jr.		24a. REC'D BY REGISTRAR OCT 23 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines		DATE OCT 23 '61	

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ALL-ARMY

General

Found Dead in Car

Los Angeles, Cal.

October 12, 1901

Spitzer

Howard

March 17, 1900

White

Male

U.S.A.

Domin, W. Va.

Insurance

Resident

Thomas J. Spitzer

Rebecca Bellamy

22-70-100A Mrs. Beulah A. Hanks Cumberland, Maryland

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W. 1

22-70-100A

Benjamin H. H. H.

Camp-Rand, Maryland

Vol. 21, 1901 Rose Hill Cemetery

Serial

Vol. 21, 1901 Frederick St. Camp, Md.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10941
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
10934

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oldtown</u>		c. LENGTH OF STAY IN 1b <u>48</u> years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oldtown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eugene</u> Middle <u>Edwin</u> Last <u>Steckman</u>				4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>19 61</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 10, 1878</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Espy I. Steckman</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Wise</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220 03 7657</u>		17. INFORMANT <u>Julia Steckman</u> Address <u>Oldtown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u>General Srtteriosclerosis.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr.</u> <u>20 yrs.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>On 9-9-61 when dying</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>9-9-61</u> 19 <u>61</u> , and that death occurred at <u>4:11 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>J. I. Armstrong</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>9-9-61.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>J. I. Armstrong.</u>				22d. ADDRESS <u>Paw Paw, W. Va.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 11, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oldtown Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Oldtown Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer,</u>				ADDRESS <u>Cumberland, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 13 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10942

10935

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 533 Greene St.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Hospital				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John		First F Middle T Last Trestle		4. DATE OF DEATH TO 19 61		Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/5/94		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Sheetmetal Cont. Self				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Penna, Altoona	
12. CITIZEN OF WHAT COUNTRY? U.S.A				13. FATHER'S NAME William Trostle			
14. MOTHER'S M maiden name Mary Martin				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) no			
16. SOCIAL SECURITY NO. ---				17. INFORMANT Address Mrs. Lena Trostle Cumb, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction, left ventricle 420.0 card due to healed recent postno. myocardial infarction, left, postno. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic heart disease (c) Thrombophlebitis left calf - 4 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombophlebitis left calf - 4 days INTERVAL BETWEEN ONSET AND DEATH 24 HOURS? 2 mos Unknown							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (State nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 13 Oct 1961 to 14 Oct 1961 , that (I) (we) last saw the deceased alive on 13 Oct 1961 , and that death occurred 14 Oct 1961 AM, from the causes and on the date stated above.							
22a. SIGNATURE St. G. WEISMAN MD				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/15/61	
22c. PHYSICIAN'S NAME (Type) St. G. WEISMAN MD				22d. ADDRESS 54 GREENE ST, CUMBERLAND, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/17/61		23c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Pk.		23d. LOCATION (City, town or county) (State) Cumberland MD	
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				ADDRESS Cumb, MD.		25a. REC'D BY REGISTRAR OCT 17 '61	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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John F. Smith (100. 100)

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James F. Smith (100. 100)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

B.P. 1

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10943						10936					
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last GUY LOUIS VIRTS						4. DATE OF DEATH Month Day Year OCTOBER 28- 19 61					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-17-1893		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN				10b. KIND OF BUSINESS OR INDUSTRY Willison Oil Co. West Virginia				11. BIRTHPLACE (County & State, or foreign country) U.S.			
13. FATHER'S NAME LOUIS VIRTS				14. MOTHER'S MAIDEN NAME MINNIE RILEY VIRTS				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 220-03-7105				17. INFORMANT Mrs. Guy Virts, 221 Balti. St., Cumb. Md.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 451X DUE TO - UREMIA - Renal Failure 15 days Dissecting Aneurysm of Thoracic Aorta & Dissection to Renal Arteries 15 days Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Essential Hypertension INTERVAL BETWEEN ONSET AND DEATH 5 days 15 days with trauma			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 10				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10/13 to 10/28 , 19 61 , that (I) (we) last saw the deceased alive on 10/28 , 19 61 , and that death occurred at 6 PM , from the causes and on the date stated above.											
22a. SIGNATURE [Signature] M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/29/61			
22c. PHYSICIAN'S NAME (Type) DR. S.G. WEISMAN						22d. ADDRESS 596 Green St Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/31/61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.						25a. REC'D BY REGISTRAR DATE NOV 2 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Finner			

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10945

10938

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Vale Md.</u> c. LENGTH OF STAY in 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>752 National Hwy</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Vale Md.</u> d. STREET ADDRESS <u>752 National Hwy</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Phillip M. Walker</u>				4. DATE OF DEATH <u>Oct 7 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 28, 1904</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		10. UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>5410ct store</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Wishaw Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u> </u>			
13. FATHER'S NAME <u>Phillip J. Walker</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hatalsky</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>307-03-2464</u>			
17. INFORMANT <u>Mrs. Iona Walker (Same)</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u> <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-3-1959</u> , to <u>10-7-1961</u> , that (I) (we) last saw the deceased alive on <u>10-5-1961</u> , and that death occurred at <u>2A</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>L. Brins</u>				22b. DATE SIGNED <u>10-9-61</u>			
22c. PHYSICIAN'S NAME (Type) <u> </u>				22d. ADDRESS <u> </u>			
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/10/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter & Paul Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James Stein Inc</u>				25a. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

OCT 13 '61

Arthur S. Hines

TO FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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James Allen Inc. 10/10/01 22 Pct + Profit Com. Guaranteed, 100%

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James Allen Inc. 10/10/01 22 Pct + Profit Com. Guaranteed, 100%

James Allen Inc. 10/10/01 22 Pct + Profit Com. Guaranteed, 100%

James Allen Inc. 10/10/01 22 Pct + Profit Com. Guaranteed, 100%

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10946
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10939

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 434 Laing Avenue				d. STREET ADDRESS 434 Laing Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Ida Middle Belle Last Wilson				4. DATE OF DEATH Month October Day 11 Year 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/24/1878	
9. AGE (In years lost birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MURLEYS BRANCH	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John Middleton				14. MOTHER'S MAIDEN NAME Permelia Hardman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Julia Snider Address 434 Laing Ave., Cumb. Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Concussion of Brain</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 181.0 (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> 19 <i>61</i> to <i>Sept 11</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>Sept 11</i> 19 <i>61</i> , and that death occurred at <i>3 P</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>R. Mathews</i>				22b. DATE SIGNED 10/12/61		22c. PHYSICIAN'S NAME (Type) DR. R. B. MATHEWS	
22d. ADDRESS 49 Gravena Street				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/14/61		23c. NAME OF CEMETERY OR CREMATORY Mt. Herman, Cumb. Md.		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Hafer</i>				25a. REC'D BY REGISTRAR DATE OCT 16 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

10030

CLERK OF THE COURT

10030



TO ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10947 CERTIFICATE OF DEATH 10940											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 29 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 34 WEST FIRST STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MILDRED P WISE			4. DATE OF DEATH OCT. 1 19 61			5. SEX FEMALE			6. COLOR OR RACE WHITE		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH JAN. 28, 1900			9. AGE (In years last birthday) 61 yrs.			IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10b. KIND OF BUSINESS OR INDUSTRY Railroad			11. BIRTHPLACE (County & State, or foreign country) MARYLAND - CUMBERLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME AUGUSTUS M. TABLER						14. MOTHER'S MAIDEN NAME SAVILLA GLOVER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 705-12-5440			17. INFORMANT MEMORIAL HOSPITAL			17. Address CUMBERLAND, MARYLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis Heart Disease 260X DUE TO Conditions, if any, which gave rise to immediate cause (b) Diabetes Mellitus causing the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)
21. I certify that (I) (this hospital) attended the deceased from June 1954 to 10/1/61 , that (I) (we) last saw the deceased alive on 10/1/61 , and that death occurred 7:30 AM from the causes and on the date stated above.											
22a. SIGNATURE Dr. George M. Simons, MD						22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) Dr. George M. Simons, MD		
22d. ADDRESS Algonquin Hotel, Cumberland, Md.						22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22f. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10-3-1961			23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park			23d. LOCATION (City, town or county) (State) Cumberland, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR OCT 4 '61			25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

10330

10331



ALLIANCE	MARYLAND	29 DAYS	CUMBERLAND	ALLIANCE	MARYLAND	29 DAYS	CUMBERLAND
34 WEST FIRST STREET				34 WEST FIRST STREET			
WIFE				WIFE			
JAN. 28, 1900				JAN. 28, 1900			
MARYLAND - CUMBERLAND				MARYLAND - CUMBERLAND			
SAVILLA CLOVER				SAVILLA CLOVER			

103-12-5-100 CENTRAL HOSPITAL CUMBERLAND, MARYLAND

James M. Brown
James M. Brown

James M. Brown
James M. Brown

James M. Brown, Cumberland, Md.
 James M. Brown, Cumberland, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10948 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10941**

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 4Iyrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 02		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 213 Cecelia St.				d. STREET ADDRESS 213 Cecelia 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Effie Middle F. Last Wright				4. DATE OF DEATH Month Oct. Day 6, Year 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1877		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ownhome		11. BIRTHPLACE (State or foreign country) Augusta, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David H. Wright				14. MOTHER'S MAIDEN NAME Elizabeth Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Laurence E. Wright Oldtown Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY HEMORRHAGE; MASSIVE 468.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) EROSION OF LYMPH NODE IN BRONCHUS DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3-4 MIN (min)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 6, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10 - 9-61		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE OCT 10 '61	
				24b. REGISTRAR'S SIGNATURE <i>Arthur E. Hume</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10022 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10022

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		Jan 15, 1912		Boston, Mass.	
Cause of Death		Disease		Injury		Poison		Other	
Heart Disease		Pneumonia		Falls		Opium		None	
Manner of Death		Occupation		Education		Religion		Marital Status	
Natural		Carpenter		High School		Catholic		Married	
Signature of Examiner		Signature of Coroner		Signature of Physician		Signature of Nurse		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Examination		Time of Examination		Place of Examination		Signature of Witness		Signature of Second Witness	
Jan 16, 1912		10:00 AM		Boston, Mass.		[Signature]		[Signature]	



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH																																																	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																																																	
10949																																																	
10512																																																	
CERTIFICATE OF DEATH																																																	
1. PLACE OF DEATH a. COUNTY ALLEGANY					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND					b. COUNTY ALLEGANY																																							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					c. LENGTH OF STAY IN 1b 13 DAYS					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND																																							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL										d. STREET ADDRESS 404 MARYLAND AVENUE					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																		
3. NAME OF DECEASED (Type or print) JOHN W. YERGAN					4. DATE OF DEATH OCTOBER 4 1961					5. SEX MALE					6. COLOR OR RACE WHITE					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 11-2-1887					9. AGE (In years last birthday) 73 yrs.					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED LABORER					11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME FREDERICK YERGAN					14. MOTHER'S MAIDEN NAME CLARA MARVIN					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. 214 05 6328A					17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X DUE TO Dissecting Aneurysm of Abdominal Aorta Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO 10 yr PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 10 yr					INTERVAL BETWEEN ONSET AND DEATH 2 wks																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) June 1959 to Oct 4 1961					20g. (County) Allegany					20h. (State) MD														
21. I certify that (I) (this hospital) attended the deceased from June 1959 to Oct 4 1961 , that (I) (we) last saw the deceased alive on Oct 4 1961 , and that death occurred at 12:55 A.M. from the causes and on the date stated above.										22a. SIGNATURE Clay E. Durrett					22b. DATE SIGNED 10/6/61					22c. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT					22d. ADDRESS 236 VIRGINIA AVENUE, CUMBERLAND, MD.																								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE THEREOF OCT. 7, 1961					23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park					23d. LOCATION (City, town or county) Cumberland, Md.					23e. REC'D BY REGISTRAR OCT 10 '61					23f. REGISTRAR'S SIGNATURE Arthur L. Kraus																								
24. FUNERAL DIRECTOR'S SIGNATURE Byron Kight					ADDRESS Cumberland, Md.					25a. REC'D BY REGISTRAR OCT 10 '61					25b. REGISTRAR'S SIGNATURE Arthur L. Kraus																																		

VR A15 (4)
15M 9/60

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10048



ALLGARY

MARYLAND

ALLEGANY

CUMBERLAND

13 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

JOHN MARYLAND AVE

JOHN

M.

YERGAN

OCTOBER

WHITE

11-2-11

13

SETTLED

WHITE

CUMBERLAND, MARYLAND

FREDRICK YERGAN

CLARA MARY

MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND



DR. CLAY E. GORRETT

230 VIRGINIA AVENUE, CUMBERLAND, MD.